THIRD PARTIES IN THE MIDST OF EVERYONE'S EXPECTATIONS*

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CONTAINMENT of health care costs is one of the major, if not the dominant, domestic economic issues of this time. Seldom a day passes without some reference in the media to the high cost of health care and the enormous strain it places upon our economy. Despite slowing of the hospital inflation index from an annualized 12.1% during the early 1980s to 5.6% in 1985,[1] there is little room for comfort in finding that the cost of health care now consumes 10.7% of our Gross National Product.[2] The issue has become so important that it has drawn the collective interest and concern of federal, state and local governments, private corporations, labor unions and consumers in general. In the middle of the debate on how to address this issue in the most constructive and sensitive manner are the third party payors who insure 86% of the American population under age 65 and 30 million Medicare recipients.[3]

Thus, it is not unexpected that the final responsibility for dealing with and for implementing any policy of cost containment has devolved upon these third party carriers who now must be considered the change agents in the evolution of the American health care system.

THE CURRENT ENVIRONMENT

Cost containment is now being addressed through two major avenues: regulation and new, often innovative, methods of health care financing.

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Regulation of our health care system was initially imposed to insure compliance with such mundane things as building codes and licensure of institutions and practitioners. In 1966, with the advent of Medicare and Medicaid, regulation was extended to focus on accountability for expended funds through such mechanisms as Utilization Review Committees and subsequently Professional Standards Review Organizations. With burgeoning technology and the consequent growth of health care costs, new laws were passed during the 1970s to control capital spending through mechanisms such as the certificate of need. Subsequently Health Maintenance Organizations were mandated by federal law as an alternate system for delivering health care. Most recently DRGs have been added in an effort to contain hospital costs. Although this applies only to Medicare patients in most states, DRGs have been utilized in New Jersey for the past five years.[4] Paradoxically, there is a real question as to whether or not DRGs have achieved savings or actually increased costs. Recent estimates suggest that the program slowed the rise of inpatient expenditures to 14.5% in 1981 versus a national increase of 17.9%. However, hospital costs rose in 1982 at the highest rate—15.2% vs. 15.8% nationally—since the start of the program.[5]

In any event, the focus of regulation has shifted from issues associated with compliance to a joint emphasis on cost containment and compliance. In all this maze of regulatory law and resultant bureaucracy, the issue of how to insure quality of care has been addressed only tangentially.

Governmental approaches: The federal government has shifted the Medicare payment system to hospitals from a traditional cost reimbursement to disease-specific Diagnosis Related Groups (DRGs). The DRGs are complex to administer and the question whether effective cost containment is achieved remains to be answered. Still, although DRGs may be problematic in their effectiveness in containing costs, their imposition upon the health care system has clearly changed the behavior of institutional providers. Never have hospitals been more cost-conscious. Average length of stay declined nationally from 7.6 days in 1980 to 6.7 days in 1984,[6] services have been cut, layoffs imposed and some hospitals have closed. Overall hospital bed occupancy has declined from 77.7% in 1980 to 72.5% in 1984.[7] Projections are for further declines by 1990.[8] Physicians have been affected only indirectly by DRGs, and will remain so until they are included in the program.

State Medicaid programs have from their inception been much less liberal in funding by imposing spending capitations. However, due to the mobility of the Medicaid population, the program has proved extremely difficult to administer and has resulted in a quasi open ended financial exposure both

to states and the federal government. At least one experiment to contract out the health care of the Medicaid population to private vendors (in Massachusetts) foundered on the "freedom of choice" issue. It is an interesting paradox that such issues as freedom of choice and restraint of trade are on a collision course in the presence of cost containment.

Private approaches. Private insurance companies can no longer afford their historic posture of using health insurance as a "loss leader" to attract other business. Although still committed to writing health insurance, cost containment measures have been embraced by the private insurance industry through promotion of HMOs, PPOs, and direct contractual arrangements with hospitals where the health provider does not already pay for such services. Maxicare, Health America and Cigna Health Plan are notably successful examples of this approach; e.g., Maxicare now cares for 745,000 families, up from 87,000 five years ago.[9] In addition, where private insurers sell individual products to the consumer, several levels of insurance are offered, the so-called "menu" approach, which offers a basic package of services with varying deductibles. Additional services may be purchased on an a la carte basis.

For-profit hospitals have had singular success in keeping their own costs down through their ability to manage the types of services they deliver, thus exercising a degree of control over patient selection that not-for-profit hospitals do not enjoy. These proprietary chains have been criticized for "skimming" paying patients away from not-for-profit hospitals, leaving sicker and more costly patients to the latter group. Despite this criticism, there is no evidence that for-profit chains fail to deliver quality care at an acceptable cost, but there is no gainsaying that they are not bastions of teaching and research. As competition for patients increases within the system, both proprietary and the not-for-profit hospitals are beginning to promote their own HMO systems and, in the case of Humana, enter into both the HMO and insurance business themselves. Throughout the system, as patient care shifts from hospital to ambulatory settings, there is greater emphasis on horizontal integration of services and networking among health care organizations to maintain patient referral and to insure the most cost-effective use of services and technology. The health care provider is becoming an entrepreneur.

Where Are We Now?

In all of this ferment the system is being reshaped. Competition for patients is the order of the day with the result that price determines where the patient goes, how much service is used and how long he stays in a particu-

lar health care site. Theoretically at least, cost containment is achieved through more efficient allocation of resources.

Changes in reimbursement in the health care system has profoundly altered the behavior of institutions, physicians and consumers. Institutions have become more competitive with one another in seeking various modalities to attract and maintain a steady flow of patients to insure their survival. In many instances they have reconfigured their corporate structure to generate discretionary income through such profit-making enterprises as laboratory services or even investments in totally unrelated business activities.[10]

Physicians similarly are becoming much more conscious of the need to maintain their patient population and of their primary role in determining how health care dollars are spent. This has resulted in more involvement in institutional affairs, including decisions regarding adoption of various types of technology and its utilitization.[11] Physicians in HMOs are particularly sensitive to these issues since their compensation is adversely affected by overutilization of services or by prescribing brand name drugs over their less expensive generic equivalents. In other settings, physicians have become more organized in their relationship with institutions and third party payors. In some instances this has become adversarial such as in the case of Kartell vs. Massachusetts Blue Shield, where physicians contended that they were entitled to bill above the amount allowed by Blue Shield for various procedures (so-called "balance billing"). Although the case was decided in favor of Blue Shield on appeal, the state legislature had made the decision moot by passing a law favoring Blue Shield's stance on prohibition of balance billing. Physicians have also become a great deal more entrepreneurial in exploring those niches of providing health care thus far unaffected by changes in the reimbursement system (Emergicenters, Surgicenters, "Doc in the Box" in shopping centers, etc.). Practices are becoming more of a cash business; it is not unusual for physicians to take Master Charge, VISA, American Express or Diners' Club as a method for payment in addition to cash itself. The physician is changing his role from that of being an advocate for the patient to being an allocator of scarce resources with a strong emphasis on running a sound business. Indeed, many physicians are making career choices in which there are clear tradeoffs in favor of discretionary time at the cost of sacrificing income (e.g., HMO environment).

The consumer is adapting reasonably well to these fundamental changes in the institutions and physicians' behavior, but still expectations are high. The consumer wants 24-hours-a-day, seven-days-a-week service by high prin-

cipled, committed and readily available physicians of his choice. While expecting the highest quality of health care, consumers and politicians still believe that medical care is administered in a wasteful and inefficient way, and that "something has to be done about it." It is not surprising that when cost containment measures are imposed by a third party, the third party finds itself in a sea of unrealized expectations and misunderstandings. Part of this is because consumers in particular do not read the "fine print" of their benefits package, a measure of the lack of communication between the third party and the insured. However, frank disagreement continues among all segments of society regarding the philosophy of how and how much health care should be provided to our population. Again the third party finds itself in the middle of the debate. Regardless of the consequences of poor communication or philosophical disagreement, there is no doubt that patient access to the panoply of medical services has been diminished by reimbursement policies. An excellent example of this is such big ticket technology as magnetic resonance imaging or CT scanning. There simply is not enough of this technology available to accommodate the total demand. While the queue lengthens, little evidence suggests that the situation would be made any better logistically or otherwise if more machines were made available to the public. Demand inevitably appears to outstrip the availability of medical technology.

The result of all these changes in attitudes and practice brought on by an increasing thrust toward cost containment will be a multi-tiered system of health care consisting of those who can pay for everything (the rich), a safety net with a basic package of medical services for the poor and the middle class whose ability to pay varies. In this group, lower middle income people are particularly vulnerable to high health care costs because a catastrophic illness can plunge them into bankruptcy. How the cost of health care for this group will be paid can only be speculated upon. Many such patients will end up in city hospitals, which traditionally bear the cost of the poor; others will impose costs on private institutions willing, at least for the time, to bear such financial burdens. There is no clear or easy solution to the variety of problems in such settings, but the potential to deny necessary care to the sick is quite real.

Current Obligations of the Third Parties

The third party payor—now often also a provider of services through an HMO—has a threefold obligation. First is the obligation to pay for medi-

cally necessary services, thus to meet everyone's expectations for a third party. The second is to inform a subscriber when a service is not considered medically necessary, a judgment usually made by an outside panel of experts. The responsibility is to provide this information in a manner that does not judge the caretaker but indicates simply that the medical benefit and medical necessity are distinctive and separable, a concept not easily understood by patients and often misunderstood by the physician whose judgment appears in question. The third obligation is to inform but not to judge a provider whose practice falls outside the norm for given circumstances.

In this milieu, to the extent that the matter has been studied, patients appear reasonably satisfied with those supplying care.[12] Caretakers are for the most part acceptably compensated by known third parties. However, troublesome situations may arise from cost containment strategies that profoundly disturb the third party-caretaker relationship by highlighting problems in paying for a physician's services. While the literature is neither extensive nor exhaustive in this area, several instances may be worth examining.

For many years major third party payors have used their data base and their panels of outside experts to determine norms of practice. That information has been communicated with impressive results to practitioners who outly the norms by $\pm$1-2 standard deviations. Up to 85% of the physicians so informed revise their practices.[13] Their reasons for doing so are little discussed. Apparently, effective lack of reimbursement for their nonconforming practice and potential censure from their institution whose costs may also be uncompensated are powerful incentives to revise behavior which may have been nothing more than habitual on their part. Few, if any, patients of a given practitioner know anything at all about such communication. Arguably, there is little need for the patients to know. Problems that do arise tend to occur when a caretaker sues a third party for nonpayment and the third party defends a patient's refusal to pay the uncompensated bill. The relationship of the participants in such a controversy is immediately and, probably, irrevocably changed. In some instances a physician may consider his reputation defamed by a third party's refusal to cover a provided service and further by its insistence on informing the patient of its judgment. When tested in a Massachusetts court, a jury verdict determined that the third party was obligated to notify the patient and that such obligation was not defamatory.[14] A delicate balance in the relationship among doctor, patient and the third party has been upset.

Such individual incidents must be considered against numbers such as the following: Nationwide, Blue Shield pays out some $10 billion in claims and

rejects another $160 million annually. Medicare pays out some $10 billion and rejects $600 million.[15] These numbers reflect the long-time character of so-called traditional methods of reimbursement. What effect newer arrangements such as HMOs, PPOs and other managed care delivery and prepaid systems may impart to the individual physician-patient relationship is difficult to predict pending further experience. What bears prospective study rather than retrospective conjecture is the outcome, not of a single encounter, but of a series of interventions aimed at improving the health of a patient population whose health provider may have been effectively (albeit not technically) selected by payors and employers despite apparent advocacy of "freedom of choice."

More difficulties can be anticipated as incentives for reduced lengths of hospital stay and increased peer review influence practice patterns, and as such innovations as the MESH concept are developed.[16] Pioneered by Paul Elwood of InterStudy, the MESH concept requires corporate restructuring such that a hospital and interested members of its medical staff establish a central organization or jointly owned, usually not-for-profit, corporation which in turn provides a means for managing portions of costs that are the physician's responsibility as well as those that the hospital controls. At the same time, the concept is meant to provide a mechanism for developing shared financial incentives. A central MESH organization creates and participates in so-called MESH plans that work with individual payors such as Medicare, Medicaid, Blue Cross, commercial insurers and others.

The future of any such mechanisms cannot be predicted in a generation of patients unaccustomed to a single caretaker or caretaker site. Undoubtedly, patients will have some difficulty taking the responsibility for coping with illness in the manner that such cost containment strategies expect from patients and families.

The relationship most potentially seriously affected by cost containment strategies at this time would seem to be that between the physician and the patient. The reason is self-evident. No physician pressured to increase productivity by seeing more patients in a given span of time has the luxury of a dialogue with patients regarding the system under which he practices. Similarly, no patient hurrying and hoping to have his problem understood and cared for is likely to spend much time in discussing the details of a payment system with the physician. And herein lies another opportunity for irrevocably altering a time honored and trusting relationship through lack of communication. And the third party is once again caught in the middle.

The major irony of the various cost-containment strategies is that what hap-

pens in the patient-physician relationship will probably continue to happen for some time no matter the strategy in effect for cost containment. That is, physicians will continue to do the best they can for their patients. Patients for the most part, at least for the foreseeable future, will continue to be variably satisfied and to view their situations as individualized. Unless a caring or analytical profession undertakes to study formally the effect of cost-containment strategies on the physician-patient relationship, the effects—whatever they may be—will be a periodically noisy but not a major priority issue for the rest of this decade.

Conclusion

In looking to the future, the outlook is one for steadily increasing restraint on the number of dollars put into health care coincident with increasing requirements for accountability in all parts of the system. The growth in the physician population will produce a surplus in excess of 70,000 physicians by 1990.[17] There will be a concomitant growth in the number and variety of technologies for diagnosis and treatment. While attendant costs will be helped by a shift from hospital to ambulatory sites and more selective application of technologies, the overall cost is likely to increase due to the progressively aging population. The result will be increased monitoring and evaluation of prescribed services by a variety of innovative mechanisms for pre-admission screening, hospital utilization review, and auditing of ambulatory care. For a time there will be increased emphasis on data collection by the third parties to establish disease profiles for "fine tuning" the DRG system. However, the outlook for this system is problematic; in all likelihood there will be a shift to more arbitrary methods of payment such as capitation involving not only institutions but physicians as well. In fact, it has been estimated that 70% of the American population will be enrolled in some form of prepaid plan by 1990.[17] Thus, physicians' incomes, already reaching a plateau in the mid1980s, will decline in a setting calling for increased scrutiny of their practices by their own practice organizations, third parties and the public. As a response, more emphasis will be placed on peer review, whose findings will be added to third party databases. In this setting physicians lose both in affluence and influence.

With the multitiered system of care resulting from various reimbursement plans, the nature of the relationship among consumers, providers and third parties is bound to change. For the third party is now the gate-keeper and guarantor of "adequate" medical care, the provider is in the conflicting role of conserving resources for his own financial benefit while providing "ade-

quate'' medical care to the patient-consumer and the consumer expects to get the care necessary to treat his medical problems. How these relationships will evolve depends in large measure on how rapidly change occurs and the wisdom and sensitivity with which changes are brought about. What constitutes ''adequate'' care is not so much a challenge as insuring that it is delivered. Try as much as we would like to simplify the issues involving health care, we are not dealing with a binary equation. It is an enormously complex situation with multiple variables. The common denominator is the amount of money available and how it is to be allocated. A new equilibrium is being established which should not be a cause for despair. The challenge is to maintain quality and access and still live within the means of our society.

Change is the order of this day and of tomorrow. In all of this process the third party plays the pivotal role and thus assumes the primary responsibility of being the change agent in our health care system.

REFERENCES

1. Neely, C.: Employees likely to feel pinch of cost-cutting. *Hospitals 60*:65, 1986.
2. Health Insurance Association of America: *Source Book of Health Insurance Data 1984-1985*. Washington, D.C., 1985, p. 39.
3. Health Insurance Association of America: *Source Book of Health Insurance Data 1984-1985*. Washington, D.C., 1985, pp. 5, 28.
4. Eicher, J. A., Schneider, G. S. and Zimmerman, D. L.: Introduction to State All-Payor Prospective Payment Systems. *Health Industry Manufacturers Association*, 1985, pp. 1-13.
5. Eicher, J. A., Schneider, G. S. and Zimmerman, D. L.: Introduction to State All-Payor Prospective Payment Systems. *Health Industry Manufacturers Association*, 1985, p. 7.
6. Health Insurance Association of America: *Source Book of Health Insurance Data 1984-985*. Washington, D.C., 1985, p. 4. Survey shows hospital costs rose 4.5% in 1984. *Bus. Ins. 19*:50, 1985.
7. American Hospital Association: *Hospital Statistics*. Chicago, American Hosp. Assoc., 1985, p. 4.
8. Coddington, D. C., Palmquist, L. E. and Trollinger, W. V.: Strategies for survival in the hospital industry. *Harvard Bus. Rev. 85*:129-38, 1985.
9. Paris, E.: Hippocrates meets Adam Smith. *Forbes 137*:63-66, 1986.
10. Cunningham, L. and Koch, C. S.,: The PRIMOe Principle: Physicians in product-line marketing. *Health. Exec. 1*:40-43, 1986.
11. Meighan, S.: Going into business together: Whether we like it or not. *Health. Exec. 1*:16-20, 1986.
12. Public attitudes about the U.S. health care delivery system. *Health Ind. Today 47*:42-49, 1984.
13. Thompson, J. L. Personal communication, December 1985.
14. Provider versus Blue Cross and Blue Shield of Massachusetts. Barnstable County Superior Court, September 1985.
15. Thompson, J. L. Personal communication, December 1985.
16. Perspectives. *Washington Report on Medicine & Health*. Washington, D. C., April 29, 1985, pp. 2-3.
17. Paris, E.: Hippocrates meets Adam Smith. *Forbes 137*:63-66, 1986.